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COUNTY OF LOS ANGELES
PROBATION DEPARTMENT

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CALVIN C. REMINGTON
Interim Chief Probation Officer

November 16, 2016

TO: Supervisor Hilda L. Solis, Chair
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Calvin C. Remington
Interim Chief Probation Officer

SUBJECT: **REPORT BACK: STRENGTHENING CRITICAL INCIDENT PROTOCOLS TO PROTECT PROBATION YOUTH AND PROMOTE ACCOUNTABILITY (ITEM NO. 7, AGENDA OF AUGUST 2, 2016)**

BACKGROUND

On August 2, 2016, on motion of Supervisor Ridley-Thomas, the Board authorized the Chief Executive Officer (CEO), in coordination with the Interim Chief Probation Officer, Director of the Department of Health Services and Director of the Department of Mental Health, to report back within the next 45 days in writing on existing policies and protocols related to incidents, both critical and non-critical, that occur in Los Angeles County juvenile justice facilities, including the probation camps and juvenile halls, with the report to include:

A. A definition of what constitutes a critical versus a non-critical incident, and when and how that determination is made;

B. A description of how current policies and protocols address when, in what circumstances and what timeframe, and how involved stakeholders, such as a youth's attorney, the courts, the family or the caretakers, the Probation Administrator/On Duty Supervisor, a Department of Health Services nurse, the Interim Chief Probation Officer, and the Board of Supervisors, are notified of an incident both critical and non-critical;

C. A description of how current policies and protocols identify and, in a coordinated manner in both the short and long term, address the root causes that led to an incident, both critical and non-critical, and a youth's needs leading up to and resulting from the incident, including medical examination and trauma-informed counseling/interventions focused on healing;

D. The extent to which the reporting of critical and non-critical incidents in Los Angeles County juvenile justice detention facilities is enforced consistently with, or contrary to, the mandated child abuse reporting duty under the law;

E. A description of how internal investigations and staff discipline are administrated in instances of critical and non-critical incidents;

F. An explanation of whether stakeholders including the youth's attorney, the courts, the family, and the Board of Supervisors are notified of any administrative remedial actions taken by the Department to address critical and non-critical incidents; and

G. A description of how these policies and protocols around critical and non-critical incidents are implemented and enforced, including any training, communication, monitoring and accountability.

This report was prepared in consultation with representatives from the Chief Executive Office, the Office of the Independent Monitor, the Auditor-Controller's Office, and the Office of Child Protection, and provides responses to the above directives.

In addition, the Board authorized the Auditor-Controller (A-C), in coordination with the Interim Chief Probation Officer, the CEO, the Chief Attorney of the Office of the Independent Monitor, the Director of the Office of Child Protection, and County Counsel, to report back within 90 days on the types and prevalence of critical incidents that have occurred over the past three years. The A-C has discussed with us their findings which include significant issues relating to the reporting, tracking, and maintenance of critical incidents. In consideration of their recommendations, we have already begun their implementation. As a result of the A-C's preliminary audit observations, our documentation, tracking system, and overall critical incident reviews will be more comprehensive as our process is strengthened.

OVERVIEW

Pursuant to the Board motion, the Probation Department, the Department of Mental Health, and the Department of Health Services - Juvenile Court Health Services (JCHS) have prepared the responses reflected in Attachments I, II, and III, respectively.

While all three Departments have policies and procedures in place relative to critical incident reviews pertaining to the juvenile hall and camp facilities, it is apparent that some protocols and practices are more refined than others. Consequently, action will be taken where needed to strengthen protocols, including conducting periodic examination of existing critical-incident-related protocols. We anticipate achieving better service delivery and youth outcomes. The following provides an overview of the Department's responses to the motion.

Probation

As indicated in Attachment I, the Probation Department is committed to revisiting Directive 1264 and other related Directives to determine whether the current categories that are classified as "critical incidents" need to be revised to be more specific. In addition, the Department acknowledges that some Directives may need to be updated, including Directive 1534 to reflect current practices. Furthermore, Probation Department policy does not provide for notifying defense attorneys of critical incidents. However, in consultation with the Office of Child Protection, County Counsel, and the Office of Independent Monitor, discussion is underway regarding providing such notification.

The Department, in consultation with the Office of the Independent Monitor, is working toward reinstating, with modifications, a "Critical Incident Review" (CIR). The reinstatement of a "Critical Incident Review" (CIR) will assess a critical incident in order to identify strengths and weaknesses of existing policies and procedures at the time of the critical incident. The intent of the impending, modified CIR, is to inform future training requirements and new policy development. The aim of a CIR is to mitigate the likelihood of similar critical incidents re-occurring, as part of the Department's continuous effort to improve service delivery in the juvenile halls and camps to improve youth outcomes.

Draft CIR Policy Under Review – The Department is in the process of reviewing a draft CIR Policy prepared by the Office of the Independent Monitor. The purpose of the new policy will include the following changes and objectives:

- To formally reinstate a process, with modifications, for rapid and timely review of egregious and/or substantial events which have the potential to adversely impact the Department.

- To provide a forum in which to discuss immediate corrective action.

- To identify systemic issues, facility weaknesses, tactical shortcomings, and/or training needs.

- To control the information disseminated to key stakeholders by recommending, when necessary, the release of information to dispel rumors, correct inaccurate information, or address general concerns.

Final CIR Policy and Implementation – We anticipate finalizing the CIR policy in November 2016, with immediate implementation upon codification of the policy. However, in the interim, the Department will continue to conduct ad hoc critical incident reviews of incidents. There will be a periodic review of the policy to ensure it is updated accordingly as strengths and weaknesses are identified.

Mental Health

As indicated in Attachment II, the Department of Mental Health already has an established, formal CIR process. The Department conducts a Manager Review of Event which requires the reporting manager to respond to a set of questions designed to identify all contributing factors which are relevant to the event. LACDMH Clinical Risk Management (CRM) collaborates with managers in identifying contributing factors and corrective actions to improve systems and prevent future occurrences. The Department's CRM conducts regular reviews of selected Clinical Events with members of the LACDMH Quarterly Risk Management Committee for purposes of risk mitigation and for improving the mental health care provided by LACDMH.

Based upon Probation Directive 1073 "Revision of Request for Mental Health Consultation Form", Probation refers any youth involved in fights or assaults; physical intervention incidents; attempted escapes and youth transferring in on Enhanced Supervision to DMH for assessment. This notification allows DMH to provide trauma-informed counseling/interventions where indicated. In addition, all newly admitted youth are screened and assessed for mental health issues, including trauma, and treatment is provided to those youth who require ongoing care. In addition, the Department has policy that provides staff with the reporting responsibilities for suspected child abuse and neglect. All Departmental policies and procedures are readily available to DMH staff on the intranet, with training provided during orientation and on an ongoing basis by supervisors and program managers.

Health Services – Juvenile Court Health Services

As reflected in Attachment III, as JCHS is part of the Department of Health Services (DHS), there are annual reviews of DHS policies and in addition to the JCHS Orientation/Re-orientation Handbook. Any revised or new policies / procedures are usually communicated to JCHS employees through email blasts and periodic staff meetings. Annual or refresher trainings are often conducted through the Learning Net. Additional in-person trainings are also set-up when needed (e.g. Trauma Informed training). JCHS also undergoes planned Quality Improvement activities to monitor the quality and appropriateness of health care delivery to the youth.

CONCLUSION

Overall, the Probation Department anticipates achieving an improvement in the level of care and institutional accountability as we move toward the full reinstatement of a formalized Critical Incident Review process. The implementation of a formalized process will provide for better enforcement and increased transparency and accountability. In addition, we look forward to cultural change and implementing results-oriented systemic reforms in response to the Board-approved motions related to having a permanent body to conduct effective Departmental oversight, as well as implementing impending Resource Development Associates' recommendations related to their review of the Department's structure and exploring best probation practice models.

In the meantime, we will continue working with our partners on strategies to strengthen critical incident reviews that will assist with the goal of mitigating the occurrence of critical incidents in our juvenile halls and camps.

Please contact me if you have any questions or require any additional information. Your staff may also contact David Mitchell, Acting Deputy Chief, Residential Treatment Services Bureau, Probation, at (562) 940-2508, Karen Streich, Mental Health Clinical Program Manager III, Department of Mental Health, at (213) 738-2895, or David Oh, MD, Interim Medical Director, Juvenile Court Health Services, at (323) 226-8723.

CCR:DM:SP:DA

Attachments (3)

c: Honorable Michael I. Levanas, Presiding Judge of the Juvenile Court
Sachi A. Hamai, Chief Executive Officer
Lori Glasgow, Executive Officer, Board of Supervisors
Mary C. Wickham, County Counsel
John Naimo, Auditor-Controller
Mitchell Katz, Director, Health Agency
Jonathan E. Sherin, Director, Department of Mental Health
Debra Duardo, Superintendent, LACOE
Michael Nash (Ret. Judge), Director, Office of Child Protection
Cynthia Hernandez, Chief Attorney, Office of the Independent Monitor
Justice Deputies

PROBATION DEPARTMENT

STRENGTHENING CRITICAL INCIDENT PROTOCOLS TO PROTECT PROBATION YOUTH AND PROMOTE ACCOUNTABILITY

As requested by the Board on August 2, 2016, the following provides the Probation Department's responses to the criteria identified in the motion related to strengthening critical incident protocols to protect probation youth and promote accountability.

Specifically, the Board authorized the Chief Executive Officer, in coordination with the Interim Chief Probation Officer, Director of the Department of Health Services and Director of the Department of Mental Health, to report back within the next 45 days in writing on existing policies and protocols related to incidents, both critical and non-critical, that occur in Los Angeles County juvenile justice facilities, including the probation camps and juvenile halls, with responses to include the following:

A. A definition of what constitutes a critical versus a non-critical incident, and when and how that determination is made.

The Los Angeles County Probation Department, since the issuance of Notice 1534 in 2007, has defined a critical incident as, *"An occurrence (incident) of significant proportion involving actual or potential liability, serious injury, significant loss, or major conflict occurring within the Probation Department's arena of responsibility."*

Pursuant to Directive 1264 issued o June 20, 2011, Critical incidents include:

- Any major disturbance (10 or more persons involved)
- Any escape other than those from open placements
- Any situation endangering probationers, staff, or the facility
- Any significant medical incident or serious injury requiring transport to an off-site medical facility
- Any incident or situation that may generate media interest, may result in litigation, or is likely to come to the attention of the Board of Supervisors
- Any incident or situation in which it is likely the Chief Probation Officer may be contacted
- Any act of violence resulting in serious injury to, or the death of a probationer

The following are types of incidents that although important, **may not** meet the "critical" incident definition, and thus, are considered, "non-critical" incidents:

- Illnesses that do not require hospitalizations.
- Injuries to youth that do not result in hospitalizations

- Preliminary Incident Notifications[1] (PINs) and Special Incident Reports (SIRs)[2] that do not trigger an Internal Affairs referral or Critical Incident Review.

Reporting of these non-critical incidents is conducted in accordance with protocol as specified in the chart under Section B.

In addition, most incidents are determined to be critical or non-critical, at the time of their occurrence, based on what constitutes critical or non-critical incidents, as defined above. In addition, there are incidents where such determination is made after further review.

Impending Review and Revision of Existing Directives, As Necessary

On September 13, 2016, the Auditor-Controller's Office conducted a meeting to discuss the August 2, 2016 motion. The meeting attendees consisted of representatives from the Chief Executive Office, the Auditor-Controller's Office, County Counsel's Office, the Office of the Independent Monitor (OIM), the Office of Child Protection, and the Probation Department.

During the meeting, the Probation Department committed to revisiting Directive 1264 and other related Directives to determine whether the current categories that are classified as "critical incidents" need to be revised to be more specific. In addition, the Department acknowledges that some Directives may need to be updated, including Directive 1534, to reflect current practices. For example, the Department is considering including suicides and attempted suicides as separate "critical incident" categories, which currently trigger notification protocols.

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[1] **Directive 1027** (issued in 2005), mandates that a PIN, a written document, be generated when any serious incident occurs in juvenile detention camps. A serious incident is defined as an escape, a serious injury to a minor, a serious disturbance, an intrusion, a natural disaster, or any other "high interest incident."
Other Directives instruct Probation personnel to fill out PINs in other situation such as the following:
Directive 1123 (issued in 2007), which pertains to crime scenes (sexual assaults, possession of weapons, and possession of controlled substances), requires the generation of a PIN. Depending on the facts surrounding this latter list, the incident may not be characterized as "critical" (the amount of controlled substance seized was so minute as to be insufficient to submit for chemical testing; the weapon was a sharpened pen cap, e.g.).
Directive 852 (issued in 2002), mandates the filling out of a PIN in circumstances of alleged criminal conduct by a minor while in the Department's custody.

[2] SIRs are reports that are generated when any staff observes and/or participates in an incident not involving a physical intervention.

B. A description of how current policies and protocols address when, in what circumstances and what timeframe, and how involved stakeholders, such as a youth's attorney, the courts, the family or caretakers, the Probation Administrator/On-Duty Supervisor, a Department of Health Services nurse, the Interim Chief Probation Officer, and the Board of Supervisors, are notified of an incident, both critical and non-critical.

Based on the Department's current policies and protocol, the following chart identifies when, in what circumstances trigger the notifications, and the timeframe in which involved stakeholders are notified of both, critical and non-critical incidents.

As indicated in the chart on the following page, another key topic of discussion during the September 13, 2016 meeting was that currently, Department policy does not provide for notifying defense attorneys of critical incidents. However, in consultation with the Office of Child Protection, County Counsel, and the Office of Independent Monitor, Departmental discussion is underway regarding such notification.

CRITICAL AND NON-CRITICAL INCIDENT NOTIFICATION TO INVOLVED STAKEHOLDERS BASED ON CURRENT POLICIES & PROTOCOLS

Party Notified (Order per Motion)	Timeframe	Trigger Notification Circumstances & Applicability to Critical or Non-Critical Incidents
Attorney	No notification provided. However, discussion underway.	Attorney notification is currently <u>not</u> provided for in Department policy. As a result, notification to both defense and prosecution attorneys was discussed at the September 13, 2016 meeting with representatives from the Office of Child Protection, Office of the County Counsel, the Office of the Independent Monitor, Chief Executive Office, and Auditor-Controller's Office. Overall, the Department's notification protocol is under review. ***(Applicable to critical incidents, pending)***
Court	Immediately	**Directive 867:** All serious injury, illness, or attempted suicide must be reported to the court on the appropriate form (Probation Form 804 for Camps; Detention Observation Report for Halls). ***(Critical incidents)*** **Directive 1027:** If there is a serious injury to a minor, the court shall be notified and it should be documented in the Preliminary Incident Notification. ***(Critical incidents)***
Family (Parent or Guardian)	Within 24 hours	**Directive 1027:** At least three telephonic contacts to the parent/guardian need to be attempted within a 24-hour period of a "serious incident" occurring (i.e., an escape, or transport to a hospital). If no telephonic contact was made, a written notification is required via certified mail. ***(May be applicable to critical and non-critical incidents, if they meet the "serious incident" criteria, as defined in Directive 1027.)***
Probation Administrator/ Supervisor	Within 15 minutes, or within 4 hours, as applicable.	**Directive 1194:** Within fifteen (15) minutes of containing an incident, the Shift Leader shall contact the Duty Supervisor and advise the Duty Supervisor that an SCM incident occurred. ***(Critical and non-critical incidents)*** **Directive 1133:** Within fifteen (15) minutes, any time an SCM Physical Intervention Incident is concluded, the Lead Staff shall notify the Duty Supervisor at their work location. ***(Critical and non-critical incidents)*** **Directive 1027:** The facility Director, or designee, shall ensure that the Bureau Chief is contacted immediately via telephone and the written Preliminary Incident Notification form is forwarded to the Bureau Chief, Regional Directors, Consultant, and Special Assistant within four (4) hours of the incident. ***(Critical and non-critical incidents)*** *(Continued on next page)*

Party Notified (Order per Motion)	Timeframe	Trigger Notification Circumstances
Health Services-JCHS Nurse	Within 30 minutes	**Directive 1133:** Any time a minor housed in a Probation facility is injured or involved in an SCM physical intervention, he/she must be presented to medical staff (nursing) for assessment within thirty (30) minutes of the injury. ***(Critical and non-critical incidents)*** **Directive 1194:** Any minor involved in a physical altercation intervention shall be referred to medical staff for assessment within 30-minutes following containment of the occurrence. It is expected that medical staff shall assess the minor(s) immediately upon presentation. ***(Critical and non-critical incidents)***
Chief Probation Officer	Immediately	**Directive 1264:** Probation staff shall immediately report all critical incidents to their Supervisor, Officer of the Day, or Acting Director, who will then immediately alert the Director, Program Manager or designee, who is then responsible for notifying the Bureau Chief by telephone and the Chief Probation Officer, Chief Deputy and Deputy Chief via e-mail. ***(Critical and non-critical incidents)*** **Directive 1027:** A Preliminary Incident Notification report must also be submitted to the Bureau Chief by the Director within four (4) hours of the initial notification. The Bureau Chief will confirm that the Deputy Chief is notified. The Deputy Chief will then report the incident directly to the CPO. ***(Critical and non-critical incidents)***
Board of Supervisors	Immediately	**Directive 1264:** The respective Deputy Chief shall provide immediate initial notification of all critical incidents to the Board of Supervisors and CEO. In addition, when notifying the Board, as a long-standing practice, notifications are also provided to the Court, Office of the County Counsel and the impacted Departments. ***(Critical incidents)***

C. A description of how current policies and protocols identify and, in a coordinated manner in both the short and long-term, address the root causes that led to an incident, both critical and non-critical, and a youth's needs (i.e., medical, health and trauma) leading up to and resulting from the incident, including medical examination and trauma-informed counseling/interventions focused on healing.

Notice 1534: Critical Incident Review Process – Notice 1534 outlines the Critical Incident Review process. Although this Notice has not been rescinded, it is also not currently being followed, as the Critical Incident Review Unit became non-operational in 2009 because of personnel reassignments and desire for efficiency in the review process.[3] (The former CIR process could take up to three to six months and, thus, was not timely.) However, critical and non-critical incidents have been, and continue to be, regularly reviewed within the operations bureaus. Referrals of suspected policy violations and misconduct are made to Internal Affairs and/or other investigative bodies. This process contributed to improved internal coordinated protocols. There is Departmental consensus that when operational, the Critical Incident Review process served effectively and provided clarity on reforms needed. Consequently, the Department, in consultation with the Office of the Independent Monitor (OIM), has begun to work toward reinstating, with modifications, a "Critical Incident Review" (CIR). The Quality Assurance Services Bureau (QASB) was recently identified as the Bureau responsible for conducting all CIRs for our juvenile institutions. The QASB has begun conducting CIRs for those critical incidents that have been identified. The new process was designed to identify successful strategies utilized, as well as potential deficiencies made during the incident. All CIRs will be reviewed and discussed during weekly meetings comprised of various management levels across various Bureaus. The Review Panel will focus on evaluating the CIR and will provide executives with a factual basis response for corrective action and provide clear guidance to managers regarding expectations. OIM will also follow up and provide additional review and insight to address the causes of any issues that may have resulted in the incident. This information is shared across Probation facilities to address similar problems that may arise.

Reinstatement of a "Critical Incident Review" – The reinstatement of a "Critical Incident Review" (CIR) will assess a critical incident in order to identify strengths and weaknesses of existing policies and procedures at the time of the critical incident. The intent of the impending, modified CIR is to inform future training requirements and new policy development. The aim of a CIR is to lessen the likelihood of similar critical incidents occurring, as part of the Department's continuous effort to enhance service delivery in the juvenile halls and camps for improved youth outcomes. The Department is in the process of finalizing the revised Directive 1534, which incorporates input from its various Bureaus and OIM.

[3] Office of the Independent Monitor Annual Report (April 2016, pg. 64-67).

Learning of and Addressing Root Causes – Referrals made to the Internal Affairs Office result in administrative investigations. These investigations can assist the Department in learning of some of the root causes that may have led to an incident, resulting in identifying strengths and weaknesses of policies and procedures.

Youth Needs Leading Up to the Incident and Healing – Pursuant to the Probation Department's policies and procedures, each youth entering the halls and camps is assessed upon intake for any needed medical, mental health, and education services. Upon a youth's intake at camp, a more in-depth analysis via a Multi-Disciplinary Assessment consisting of health, mental health, and educational needs, along with a review of the youth's delinquency history, is conducted. This will determine which camp is most appropriate based on the youth's needs. In addition, within 10 days of a youth's intake at camp, a case plan is developed specifically tailored to each youth's needs by a Multi-Disciplinary Team consisting of representatives from DMH, JCHS, Probation, LACOE, parents, attorneys, and social workers. Throughout a youth's stay at camps, in the event of a youth experiencing a crisis, Multi-Disciplinary Team reviews are conducted, as needed. Overall, as part of the healing process, throughout a youth's stay at camp, these and other interventions are provided as scheduled. Anytime a youth is involved in a critical incident, a referral for a mental health consultation is automatically submitted by the Department to DMH and, if necessary, the youth is escorted to JCHS, if applicable.

Any additional services are also provided on an as-needed basis to help youth with their needs, related to any incidents that may occur, including allowing the youth to communicate with his or her parents/guardians. Youth may also submit confidential referrals directly to DMH and JCHS at any time. However, health and/or mental health consultations that may be associated with the incident remain the purview of DMH and other licensed clinicians.

Youth's Needs Resulting from an Incident and Healing – As specified in Directives 1133 and 1194, related to both medical and mental health assessments, any time a minor housed in a Probation facility is injured in an incident or physical intervention, s/he must be presented to medical staff (nursing) for an assessment and medical examination within 30 minutes of the incident. The medical referral is noted in PIN/SIRs, along with the time elapsed before medical evaluation.

Subsequent to any physical intervention, as well as other incidents, including emotional instability, trauma, or at the request of a youth or his/her family, staff are responsible for making an immediate "Request for Mental Health Services Referral" to DMH for the minor involved. A explanation of the minor's behaviors, along with facts about the incident leading up to the referral, are detailed in the request so that a DMH clinician can then assess the minor's needs, how to best address them, and how to help in the healing process.

D. The extent to which the reporting of critical and non-critical incidents in Los Angeles County juvenile justice detention facilities is enforced consistently with, or contrary to, the mandated child abuse reporting duty under the law.

Pursuant to Directive 1187, all sworn Probation staff are mandated reporters and as such are required by "The California Child Abuse and Neglect Reporting Act" to report all instances of suspected child abuse to local law enforcement. Furthermore, the Probation Department requires that all incidents involving excessive or unnecessary force are to be reported immediately to the Internal Affairs Office so that an internal investigation can be initiated to determine if the suspected abuse took place and whether or not corrective action or discipline is required. When a violation of reporting policy is suspected, it is referred to the Department's Internal Affairs for an administrative investigation to determine any needed corrective action or discipline.

E. A description of how internal investigations and staff discipline are administered in instances of critical and non-critical incidents.

As previously indicated, critical incidents in the Probation Department are defined by Probation Directive 1264. Initial notifications to the Board offices, CEO, and the Court are completed by the Deputy Chief or designee. In addition, when notifying the Board, CEO and the Court, as a long-standing practice, notifications are also provided to the County Counsel and the impacted Departments. If applicable, a County Security Incident Report, as described under Section A, is completed and forwarded to the Security Operations Unit and/or a referral is made to the local law enforcement agency.

Internal Investigations and Staff Discipline – When a critical incident occurs, Department employees, at any level, may request an internal review of the incident. Department managers at the impacted institution will then decide, based on the information of events, whether or not to refer the case to Internal Affairs or to conduct its own facility review of the alleged incident. A referral to Internal Affairs is made, if staff misconduct or negligence is suspected. Incidents that involve staff performance are handled by the home Bureau of the involved staff. Certain types of critical incidents, such as any in-custody deaths, and escapes, are always referred to Internal Affairs.

Internal Affairs will review each referral and determine whether to initiate an investigation of the incident, refer the case back to the institution or another investigative jurisdiction (Bureau, Auditor-Controller, or CEOP Office), or close the case altogether. Guidelines that delineate which jurisdictional body is responsible for each type of investigation are set in Directive 964. Internal Affairs Investigations are conducted in accordance with existing internal policies including agreements made pursuant to existing Settlement Agreement(s) with the United States Department of Justice. Incidents are referred via internal group emails. Disciplinary action in the Probation Department is guided by the Countywide Disciplinary

Guidelines, which were developed in consultation with Probation Department Professional Standards. Disciplinary action is also guided by Probation Department Supplemental Disciplinary Guidelines, which include consequences that are specific to Probation staff.

When imposing discipline, Performance Management Unit staff draft a recommendation to the appropriate manager. The recommendation includes the range of discipline dictated by the guidelines as well as the disciplinary history of that employee. Other relevant factors, including recommendations by the Office of the Independent Monitor, are also considered. A manager in the employee's chain of command is the ultimate decision-maker. The decision-maker changes as the severity of the imposed discipline increases.

F. **An explanation of whether stakeholders including the youth's attorney, the courts, family, and the Board are notified of any administrative remedial actions taken by the Department to address critical and non-critical incidents.**

Draft CIR Policy Under Review – In an effort to mitigate the occurrence of critical incidents, the Department is proceeding to reinstate a CIR Unit and is in the process of reviewing a draft CIR Policy prepared by the Office of the Independent Monitor. The purpose of the new policy will include the following changes and objectives:

- To formally reinstate a process, with modifications, for rapid and timely review of egregious and/or substantial events which have the potential to adversely impact the Department.

- To provide a forum in which to discuss immediate corrective action.

- To identify systemic issues, facility weaknesses, tactical shortcomings, and/or training needs.

- To control the information disseminated to key stakeholders by recommending, when necessary, the release of information to dispel rumors, correct inaccurate information, or address general concerns.

Final CIR Policy and Implementation – We anticipate finalizing the CIR policy by mid-December 2016, with subsequent implementation within six months. There will be a periodic review of the policy to ensure it is updated accordingly to reflect strengths and weakness as identified.

Notification to Stakeholders of Administrative Remedial Actions – Regarding the notification to stakeholders, including the youth's attorney, the courts, family, and the Board, of Administrative remedial actions of critical and non-critical incidents: Non-confidential information is disclosed to parents, such as the youth's relocation or transfer to a different facility; however administrative actions involving

staff may be confidential and protected by statute or other privileges, therefore may not be communicated to the parents, court or the minor's attorney. However, the Department notifies the Board, to the extent permissible by law, of the Department's Administrative remedial actions. Due to potential exposure to litigation, the Department may not disclose any information that will result in conflicts with laws or MOUs, etc.

G. A description of how these policies and protocols around critical and non-critical incidents are implemented and enforced, including any training, communication, monitoring and accountability.

Policy Communication, Implementation, Monitoring, and Enforcement – All staff are trained upon hiring regarding Probation's policies and procedures including those related to critical incidents and the reporting thereof. Staff may also review policies and directives which are located on Probnet, the Department's "intranet". Revised or new policies or directives are also communicated to all employees via e-mail blasts. In the halls and camps, Unit dorm meetings are held with staff to discuss revised or new policies and directives. When an allegation of policy violation related to critical and non-critical incidents is substantiated, staff are held accountable through the disciplinary process.

Revised or New Policies Training – As revised or new protocols are established, follow-up training is provided accordingly. All staff are required to take yearly, mandatory certified training classes which include Enhanced Supervision, Child Abuse Reporting, Safe Crisis Management, Standard First Aid, and Suicide Prevention.

As part of the Hope Center Pilot Training Program, an initial group of staff are receiving training in Trauma, Dialectical Behavior Therapy, and Case Management. In addition, all staff are provided with De-Escalation Training. The Department will continue to identify various training curriculums that will assist with the reduction and/or the avoidance of critical incidents.

Lessons Learned – The formal CIR Unit should have been streamlined, or a comparable process maintained, as a top Departmental priority and remained operational despite the personnel reassignments. A more periodic review of directives, policies, and manuals is necessary to ensure they are updated accordingly. In addition, the creation of a centralized log of all critical notifications to the Board is necessary to expeditiously account for incidents that occurred in prior years. These will be addressed accordingly by the Department.

DEPARTMENT OF MENTAL HEALTH

STRENGTHENING CRITICAL INCIDENT PROTOCOLS TO PROTECT PROBATION YOUTH AND PROMOTE ACCOUNTABILITY

As requested by the Board on August 2, 2016, the following provides the Department of Mental Health's responses to the criteria identified in the motion related to strengthening critical incident protocols to protect probation youth and promote accountability.

Specifically, the Board authorized the Chief Executive Officer, in coordination with the Interim Chief Probation Officer, Director of the Department of Health Services and Director of the Department of Mental Health, to report back within the next 45 days in writing on existing policies and protocols related to incidents, both critical and non-critical, that occur in Los Angeles County juvenile justice facilities, including the probation camps and juvenile halls, with responses to include the following:

A. A definition of what constitutes a critical versus a non-critical incident, and when and how that determination is made.

Los Angeles County Department of Mental Health ("LACDMH") staff working within the juvenile justice facilities, including the probation camps and juvenile halls comply with the LACDMH Policy/Procedure Number 303.05 regarding "Reporting Clinical Events Involving Active Clients." This policy defines what is considered to be a Critical Clinical Event. Specifically, a Critical Clinical Event is *"an event that has or may generate governmental and/or immediate community-wide attention and may require a notification by the LACDMH to the Board of Supervisors."* In LACDMH Policy Number 303.05, a clinical event involving an active client is described in fourteen (14) different categories:

1. Death - Unknown Cause;
2. Death - Suspected or Known Cause Other Than Suicide;
3. Death - Suspected or Known Suicide;
4. Suspected or Known Suicide Attempt Requiring Emergency Medical Treatment (EMT);
5. Client Self-injury Requiring EMT (not suicide attempt);
6. Client Injured Another Person Who Required EMT;
7. Suspected or Alleged Homicide by Client;
8. Medication Error
9. Suspected or Alleged Inappropriate Interpersonal Relationship With Client by Staff;
10. Threat of Legal Action;
11. Client assaulted by another client requiring EMT;
12. Adverse Drug Reaction Requiring EMT;
13. Alleged Assault by Staff Member To Client
14. Inaccurate or Absent Laboratory Data Resulting in a Client Requiring EMT Treatment

Please note that unlike most event reporting, a large proportion of the DMH Critical Clinical Incidents are events that normally do not take place when providing services. However, for Quality Improvement purposes it is important to track these incidents and review the services that were provided. The policy outlines the procedure for reporting clinical events, including filing a Clinical Event Report (CER) in the Safety Intelligence (SI) online reporting system.

B. A description of how current policies and protocols address when, in what circumstances and what timeframe, and how involved stakeholders, such as a youth's attorney, the courts, the family or caretakers, the Probation Administrator/On-Duty Supervisor, a Department of Health Services nurse, the Interim Chief Probation Officer, and the Board of Supervisors, are notified of an incident, both critical and non-critical.

Depending upon the nature of the Critical Clinical Event, LACDMH communicates with the on-site interagency partners, such as the Probation Department and Juvenile Court Health Services, for purposes of continuity and coordination of care. Due to the residential and inter-departmental environment which exists in the juvenile justice programs, typically the on-site partners are aware of any of the Critical Clinical Incidents listed above. There is a multi-disciplinary approach to treating youth and important information is shared on a need to know basis. LAC-DMH may also communicate with the youth's family where clinically indicated. Within the juvenile justice system, youth typically consent for treatment received. Additionally, with youth consent, clinical staff may inform families of Critical Clinical Incidents. For certain critical incidents, Probation notifies the family according to established directives. Generally, due to the confidential nature of Protected Health Information, LACDMH does not typically communicate with the youth's attorney or the Court unless there is a court order, or the youth has authorized the release of information.

C. A description of how current policies and protocols identify and, in a coordinated manner in both the short and long-term, address the root causes that led to an incident, both critical and non-critical, and a youth's needs (i.e. medical, health and trauma) leading up to and resulting from the incident, including medical examination and trauma-informed counseling/interventions focused on healing.

Critical Clinical Events reported using the on-line Safety Intelligence system, trigger a "Manager Review of Event" link which requires the reporting manager to respond to a set of questions designed to identify all contributing factors which are relevant to the event. LACDMH Clinical Risk Management (CRM) collaborates with managers in identifying contributing factors and corrective actions to improve systems and prevent future occurrences. CRM conducts regular reviews of selected Clinical Events with members of the LACDMH Quarterly Risk Management Committee for purposes of risk

mitigation and for improving the mental health care provided by LACDMH.

Based upon Probation Directive 1073 "Revision of Request for Mental Health Consultation Form", Probation refers any youth involved in fights or assaults; physical intervention incidents; attempted escapes and youth transferring in on Enhanced Supervision to DMH for assessment. This notification allows DMH to provide trauma-informed counseling/interventions where indicated. In addition, all newly admitted youth are screened and assessed for mental health issues, including trauma, and treatment is provided to those youth who require ongoing care. As part of this process, a mental health professional screens and completes an assessment on all newly admitted youth. The assessment includes current and historical symptoms/problems such as those related to or caused by exposure to trauma. DMH utilizes trauma-informed treatment approaches such as Seeking Safety.

D. The extent to which the reporting of critical and non-critical incidents in Los Angeles County juvenile justice detention facilities is enforced consistently with, or contrary to, the mandated child abuse reporting duty under law.

For LAC-DMH, the reporting of critical and non-critical incidents in the Los Angeles County juvenile justice detention facilities is enforced in a manner consistent with mandated child abuse reporting duties under the law. LACDMH staff working in the juvenile halls and the Probation camps follow LACDMH Policy/Procedure Number 303.02 "Reporting Suspected Child Abuse and Neglect." This policy provides LAC-DMH staff with the reporting responsibilities for suspected child abuse and neglect. LACDMH clinical staff are mandated reporters who are legally and ethically obligated to report suspected child abuse. The frequency with which LACDMH staff report child abuse is dependent on information disclosed by youth during assessment and treatment.

E. A description of how internal investigations and staff discipline are administered in instances of critical and non-critical incidents.

The LACDMH Human Resources Bureau conducts internal investigations in circumstances where there are allegations that LACDMH staff working in the juvenile halls or Probation camps have violated policies, procedures or laws. In accordance with County policy, LACDMH employees cooperate with investigations conducted by other County Departments or other investigative bodies. Any disciplinary actions are consistent with the County of Los Angeles Department of Human Resources "Countywide Disciplinary Guidelines for Employees."

F. An explanation of whether stakeholders including the youth's attorney, the courts, family, and the Board of Supervisors are notified of any administrative remedial actions taken by the Department to address critical and non-critical incidents.

Critical incidents must be reported to Office of the Medical Director within 24 hours. These reports are reviewed by executive staff. As appropriate and in accordance with, applicable regulations, reports are made to other parties for purposes of advising County executives, initiating additional actions, advising regulatory agencies, and/or supporting families and caregivers.

Departmental actions related to critical and noncritical incidents, as appropriate and based on the impact on other parties, are reported to County executives. As permitted by applicable regulations, and in consultation with County Counsel additional actions may include, advising regulatory agencies, and/or supporting families and caregivers.

With respect to incidents related to youth in custody of the Probation Department, LACDMH cooperates and coordinates with the notification processes outlined by the Probation Department.

G. A description of how these policies and protocols around critical and non-critical incidents are implemented and enforced, including any training, communication, monitoring and accountability.

All LACDMH policies and procedures are readily available to LACDMH staff on the intranet. Training is provided during orientation and on an ongoing basis by supervisors and program managers. For the clinical risk management (CLRM) policy, revisions are reviewed at the Supervising Psychiatrists, District Chiefs and Program Head meetings. In addition, CLRM staff maintain an internet webpage with PowerPoint presentations on reporting. Webinar trainings on Safety Intelligence Reporting of Clinical Events and reporting reference guide are routinely updated and communicated to staff via the CLRM website and emails to managers. CLRM presents individually at programs and through department-wide webcasts. CLRM also communicates directly with managers regarding reporting via phone and e-mail. If CLRM discovers that an event has not been reported, they contact the manager directly and ask that the report be completed.

JUVENILE COURT HEALTH SERVICES

STRENGTHENING CRITICAL INCIDENT PROTOCOLS TO PROTECT PROBATION YOUTH AND PROMOTE ACCOUNTABILITY

As requested by the Board on August 2, 2016, the following provides the responses by Juvenile Court Health Services (JCHS) to the criteria identified in the motion related to strengthening critical incident protocols to protect probation youth and promote accountability.

Specifically, the Board authorized the Chief Executive Officer, in coordination with the Interim Chief Probation Officer, Director of the Department of Health Services and Director of the Department of Mental Health, to report back within the next 45 days in writing on existing policies and protocols related to incidents, both critical and non-critical, that occur in Los Angeles County juvenile justice facilities, including the probation camps and juvenile halls, with responses to include the following:

A. A definition of what constitutes a critical versus a non-critical incident, and when and how that determination is made.

For JCHS staff, critical incidents include any level of care that requires attention higher than what is available by JCHS staff at the facility. In the case of life-threatening critical incidents, JCHS staff or Probation staff will call 911 for emergency transport to a hospital emergency room. For non-life-threatening critical incidents, JCHS staff will refer to Probation staff for transportation to a hospital emergency room.

If a youth is believed to be a present danger to self or others due to mental health or behavioral health concerns, JCHS staff will refer to Juvenile Justice Mental Health (JJMH) for evaluation and determination.

B. A description of how current policies and protocols address when, in what circumstances and what timeframe, and how involved stakeholders, such as a youth's attorney, the courts, the family or caretakers, the Probation Administrator/On-Duty Supervisor, a Department of Health Services nurse, the Interim Chief Probation Officer, and the Board of Supervisors, are notified of an incident, both critical and non-critical.

JCHS staff are instructed to communicate to the Medical Director, who will escalate communications within the DHS chain of command and/or to the Board of Supervisors.

JCHS also communicates with the Probation Department through the referrals made for incidents where a youth may be injured. Preferably, youth are brought to the medical

unit to be medically evaluated and triaged with any necessary medical interventions performed.

Probation staff are also being trained by medical staff regarding any medical signs or symptoms that they need to be aware of regarding a youth's medical status.

During times of a potential emergency, Probation may use the term "Code Blue" or "Man Down" to communicate with JCHS staff of a perceived life-threatening medical situation (Procedure # 011 – Emergency Response).

Internally, JCHS staff utilize "hand off communication" (Procedure # 014 – Hand-off Communication – Youth Care Report) where there are "*interactive communications allowing the opportunity for questioning between the giver and receiver of youth information.*" This is to "*improve communication among caregivers by using effective communication when youth care responsibilities are handed off from one healthcare provider to another*".

C. A description of how current policies and protocols identify and, in a coordinated manner in both the short and long-term, address the root causes that led to an incident, both critical and non-critical, and a youth's needs (i.e. medical, health and trauma) leading up to and resulting from the incident, including medical examination and trauma-informed counseling/interventions focused on healing.

Any critical or non-critical incident can happen to any of the youth regardless of their medical/health needs. JCHS will counsel and educate all youth regarding access to medical services from the very beginning of their admission during the Nursing Intake Assessment (Nursing Procedure #001 – Access to Care). JCHS staff also will educate whenever possible for promoting good health and anticipatory guidance (Policy #I-102 – Health Education, Health Promotion, and Preventive Care and Policy #I-103 – Health Education and Promotion of a Healthy Lifestyle).

In the case of a Fragile Youth (those youth that have medical conditions requiring more awareness and monitoring by the healthcare staff), potential issues can be minimized through frequent clinic visits and reviews of the medical chart or even referrals for further specialty care (Policy #C-208 – Medically Fragile Youth and Medical Holds). JCHS also maintains interdepartmental communication for any youth that may have particular medical needs so others may be aware of any restrictions or accommodations. (Policy #C-204 – Interdepartmental Communication on Special Needs Youth).

JCHS undergoes regularly planned Quality Improvement activities to monitor the quality and appropriateness of health care delivery to the youth (Policy #F-104 – Quality

Improvement). In the unlikely event of a youth death, Policy #C-115 (Procedure in the Event of a Youth Death) is followed.

D. The extent to which the reporting of critical and non-critical incidents in Los Angeles County juvenile justice detention facilities is enforced consistently with, or contrary to, the mandated child abuse reporting duty under law.

Licensed JCHS staff are mandated reporters according to Federal and State regulations and will actively report according to JCHS policy (Policy # F-301 – Child Abuse and Neglect, Physical and Sexual Assault Reporting). This usually involves notifying and providing a report to the Department of Children and Family Services (DCFS) through the Los Angeles Child Protection Hotline.

E. A description of how internal investigations and staff discipline are administered in instances of critical and non-critical incidents.

JCHS staff follow Policy #F-201, Event Notification Guidelines, to promptly report all incidents, events, or injuries, using the University Health Consortium Safety Intelligence Program.

In the event of a youth's death, there are both clinical and administrative joint reviews of the event according to Policy # C-115 (Procedure in the Event of a Juvenile Death). Internally, the Executive Team will perform case reviews along with any investigations with DHS Risk Management and third party administrators.

DHS Human Resources Performance Management Unit investigates and determines whether any discipline is required for staff involved.

F. An explanation of whether stakeholders including the youth's attorney, the courts, family, and the Board of Supervisors are notified of any administrative remedial actions taken by the Department to address critical and non-critical incidents.

Administrative remedial actions taken by JCHS are handled in-house and communicated to the Board through the Department of Health Services (DHS) Risk Management; administrative remedial actions are not communicated to other stakeholders.

For any health-related incident that only JCHS staff may be aware of, Probation staff will be notified of the incident. Any additional information, including notification to the parent or legal guardian of a youth involved in an emergency is typically provided through the Probation Department.

G. A description of how these policies and protocols around critical and non-critical incidents are implemented and enforced, including any training, communication, monitoring and accountability.

As JCHS is part of DHS, there are annual reviews of DHS policies and in addition to the JCHS Orientation/Re-orientation Handbook. Any revised or new policies / procedures are usually communicated to JCHS employees through email blasts and periodic staff meetings.

Annual or refresher trainings are often conducted through the Learning Net. Additional in-person trainings are also set up when needed (e.g. Trauma Informed training).

Probation provides formal training on an annual basis to JCHS employees pertaining to the identification of youth who are potentially suicidal, and the appropriate healthcare response.

COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER

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JOHN NAIMO
AUDITOR-CONTROLLER

November 18, 2016

TO: Supervisor Hilda L. Solis, Chair
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: John Naimo
Auditor-Controller

SUBJECT: **PROBATION DEPARTMENT – STRENGTHENING CRITICAL INCIDENT PROTOCOLS TO PROTECT PROBATION YOUTH AND PROMOTE ACCOUNTABILITY (August 2, 2016, Board Agenda Item 7)**

On August 2, 2016, the Board of Supervisors (Board) directed the Chief Executive Office (CEO), Probation Department (Probation), Department of Health Services (DHS), and Department of Mental Health (DMH) to report back in 45 days on existing policies and protocols related to critical and non-critical incidents that occur in Los Angeles County juvenile justice facilities, including the probation camps (camps) and juvenile halls (halls). The Board also directed the Auditor-Controller, in coordination with Probation, CEO, Office of the Independent Monitor (OIM), Office of Child Protection (OCP), and County Counsel to report back to the Board within 90 days on the types and prevalence of critical incidents that have occurred over the past three years.

Scope

Our review focused on the critical incidents that occurred at the camps and halls during Fiscal Years (FY) 2013-14, 2014-15, and 2015-16. We reviewed Probation's current policies and procedures for significant and critical incidents, Preliminary Incident Notifications (PINs), and critical incident memos Probation sent to the Board during the same three fiscal years. In addition, we met with staff from Probation, CEO, OIM, OCP, County Counsel, Public Defender (PD), and Alternate Public Defender (APD). We also contacted the State Division of Juvenile Justice, Federal Department of Justice, DMH, Juvenile Court Health Services (JCHS), and Los Angeles County Office of Education

(LACOE). We also contacted the Probation Departments in the Counties of Kern, Orange, and San Diego to compare policies and critical incident definitions.

Results of Review

Our review identified significant issues relating to the reporting, tracking, and maintenance of critical incidents which resulted in the omission of PINs and may have resulted in critical incidents not being reported to the Board as required. Specifically, Probation does not:

- Maintain a centralized tracking system for critical or non-critical incidents. Probation management indicated that some of the critical incident records were lost or misplaced, especially those relating to FY 2013-14, due to the transition of various personnel and the deletion of e-mails.

  Probation's attached response indicates that they developed a comprehensive centralized PIN and critical incident tracking system.

- Document the critical incident type being reported to identify systemic patterns that require further review and corrective action. We classified the critical incidents we reviewed and noted that 74 (49%) of the 151 critical incident types reported to the Board related to the hospitalization of youth, with 57 (77%) of the 74 hospitalizations related to a medical condition of the youth, rather than an injury. In addition, reported critical incidents involving only Probation staff were rare, totaling only ten (7%) of the 151 critical incident types. As a result, it is difficult to further evaluate whether the high number of hospitalizations or the low number of critical incidents involving only Probation staff are typical.

  Probation's attached response indicates that their new comprehensive centralized incident tracking system documents critical incident types as reported to the Board.

- Perform Critical Incident Reviews to ensure appropriate corrective action is taken to reduce the likelihood of similar incidents from re-occurring. Probation indicated that in 2009 due to staffing reassignments and budget restrictions they discontinued performing Critical Incident Reviews.

  Probation's attached response indicates that they have already re-instated a new formal Critical Incident Review process.

- Document their investigation or justification for concluding if incidents are critical or non-critical. Without documentation to support their conclusion, Probation cannot ensure all critical incidents are accurately reported.

Probation's attached response indicates that they are finalizing the changes to their policies requiring the justification for determining whether to document an incident as critical or non-critical.

- Appropriately document the notifications of incidents to the required personnel within four hours of all incidents at the camps and halls. Specifically, we reviewed 30 PINs (ten PINs from each fiscal year) and noted 12 (40%) did not include any indication that the Facility Directors notified key personnel, five (17%) did not include the time key personnel were notified, and one (3%) did not include any indication that the Facility Director notified key personnel within four hours as required.

  Subsequent to our review, Probation provided documentation to support key personnel were notified for seven of the 12 PINs, and key personnel were notified within four hours for three of the five PINs reviewed. In addition, Probation's attached response indicates that they will continue to enforce this policy and train management to ensure the policy is adhered to and proper documentation is submitted.

- Notify the youths' legal counsel (i.e., defense attorney, public defender, etc.) when a critical incident occurs. The youths' legal counsel should be aware of all critical incidents that impact their client while the youth is under the care of Probation.

  Probation's attached response indicates that they will work with the PD, APD, and Superior Court to establish a process to notify the youths' legal counsel of critical and non-critical incidents involving their clients.

In addition, we compared Probation's critical incident definition and policies with the Counties of Kern, Orange, and San Diego, and noted that Probation's definition is consistent with the three other counties. Although Probation is the lead department that reports critical incidents to the Board, Probation, DMH, JCHS, LACOE, PD, and APD do not have consistent definitions among the various entities. As a result, critical incidents may not be consistently reported, and the same types of incidents may be classified differently among the entities. In addition, Probation's policies do not include procedures for handling incidents that Probation does not classify as critical but the referring entity does, nor do they require Probation to report back to the various entities the disposition of the incident including whether it was investigated or reported to the Board as a critical incident.

Probation's attached response indicates that they will work with these partner entities to more uniformly and consistently identify these critical incidents and share information accordingly. Probation will also develop procedures for handling non-critical incidents when the referring entity considers them critical.

Review of Report

We discussed our report with Probation, CEO, OIM, OCP, and County Counsel. Probation's attached response (Attachment III) indicates agreement with our findings and recommendations. Probation, DMH, and DHS will separately respond to the first part of the motion related to their existing policies and protocols.

We thank Probation management and staff for their cooperation and assistance during our review. If you have any questions please call me, or your staff may contact Aggie Alonso at (213) 253-0304.

JN:AB:PH:AA:EB:dc

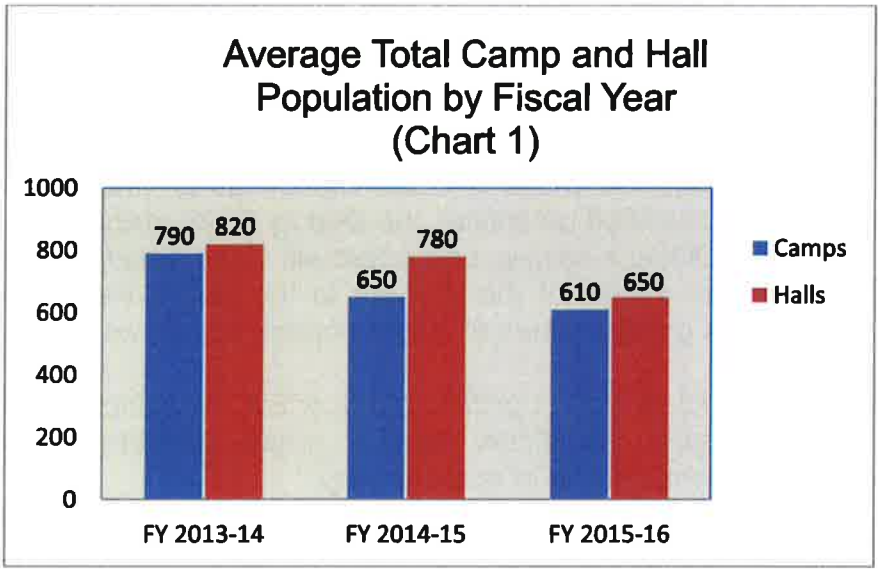
Attachments

c: Honorable Michael I. Levanas, Presiding Judge of Juvenile Court
Sachi A. Hamai, Chief Executive Officer
Calvin C. Remington, Interim Chief Probation Officer
Mary C. Wickham, County Counsel
Mitchell H. Katz, M.D., Director, Los Angeles County Health Agency
Jonathan E. Sherin, Ph.D., Director, Department of Mental Health
Cynthia Hernandez, Chief Attorney, Office of the Independent Monitor
Michael Nash, Executive Director, Office of Child Protection
Lori Glasgow, Executive Officer, Board of Supervisors
Debra Duardo, Ed.D., Superintendent, Los Angeles County of Education
Public Information Office
Audit Committee

PROBATION DEPARTMENT
STRENGTHENING CRITICAL INCIDENT PROTOCOLS TO PROTECT PROBATION YOUTH AND PROMOTE ACCOUNTABILITY

Background

The Probation Department (Probation) operates 11 probation camps (camps), one residential treatment facility, and three juvenile halls (halls). The camps provide housing in a residential setting for youth committed by the Juvenile Court, with an average stay of six months. The halls provide temporary housing for youth detained on an arrest, awaiting a court date, and/or awaiting adjudication. Youth at the camps and halls attend school and engage in recreational activities and also receive health, mental health, educational, family assessment, and transitional community services tailored to meet each individual's needs. The average population for the camps and halls for the last three Fiscal Years (FY) are illustrated in Chart 1 below:



Scope

Our review focused on the critical incidents that occurred at the camps and halls during FYs 2013-14, 2014-15, and 2015-16. We reviewed Probation's current policies and procedures for significant and critical incidents, Preliminary Incident Notifications (PINs), and critical incident memos Probation sent to the Board of Supervisors (Board) during the same three fiscal years. In addition, we met with staff from Probation, Chief Executive Office, Office of the Independent Monitor, Office of Child Protection (OCP), County Counsel, Public Defender (PD), and Alternate Public Defender (APD). We also contacted the State Division of Juvenile Justice, Federal Department of Justice, Department of Mental Health (DMH), Juvenile Court Health Services (JCHS), Los Angeles County Office of Education (LACOE), and the Probation Departments in the Counties of Kern, Orange, and San Diego to compare policies and critical incident definitions.

Reporting

Within four hours of the occurrence of a significant incident, Facility Directors at the camps and halls (or their designees) are responsible for completing a PIN and sending the PIN to key personnel including their Bureau Chief, Regional Director, and the Bureau Consultant. Probation is required to complete PINs for the following types of incidents:

- An escape.
- Any major disturbance at the facility.
- Any other situation endangering wards, staff, or the facility.
- Any medical incident or serious injury requiring transport to an off-site medical facility.
- Any incident or situation which may generate media interest or come to the attention of the Board.
- Any incident or situation in which it is likely that the Chief Probation Officer may be contacted.

Not all types of incidents reported on a PIN result in a reportable "critical" incident. The camp or hall's Deputy Chief, Bureau Chief, and Bureau Consultant review the PIN. The Deputy Chief is then required to make a determination as to whether the incident is critical. If the incident is classified as critical, the Deputy Chief prepares a Board memo for the Chief Probation Officer's review and approval. The Chief Probation Officer's designee then e-mails the details of the incident to the Board via a Critical Incident Board memo. Probation's policy defines a critical incident as follows:

> *"An occurrence (incident) of significant proportion involving actual or potential liability, serious injury, significant loss or major conflict occurring with the Probation Department's arena of responsibility."*

Probation reports the following nine types of critical incidents to the Board:

- Major disturbance (ten or more youth involved).
- Escape from camps or halls.
- Situation endangering probationers, staff, or the facility.
- Significant medical incident or serious injury requiring admission to an off-site medical facility.
- Incident or situation that may generate media interest, may result in litigation, or is likely to come to the attention of the Board.
- Incident or situation in which it is likely that the Chief Probation Officer may be contacted.
- Act of violence resulting in serious injury to, or the death of a probationer.
- Suicide attempts.
- Suicides.

It should be noted that not all critical incidents have a corresponding PIN. For incidents that may generate media interest or where the Chief Probation Officer may be contacted, Probation may not prepare a PIN. Rather, if Probation determines the incident to be critical, Probation may immediately send the Board a Critical Incident Board memo.

As previously indicated, we compared Probation's critical incident definition and policies with the Counties of Kern, Orange, and San Diego, and noted that Probation's definition is consistent with the three other counties. Specifically, all four definitions are generally broad and allow their departments the discretion to determine whether an incident is critical. In addition, neither the State Division of Juvenile Justice nor the Federal Department of Justice provides any guidance in regards to critical incident reporting.

Notification

We reviewed 30 PINs (ten PINs from each fiscal year) to determine whether the camps and halls Facility Directors appropriately notified the required personnel within four hours of the incident. We noted:

- Twelve (40%) PINs did not include any indication that the Facility Directors notified key personnel. Subsequent to our review, Probation provided documentation to support key personnel were notified for seven (58%) of the 12 PINs. However, four (57%) were submitted an average of one day late.

- Five (17%) PINs did not include the time key personnel were notified. As a result, we could not determine whether the Facility Directors notified the key personnel within the required timeframes. Subsequent to our review, Probation provided documentation to support that key personnel were notified within four hours for three PINs.

- One (3%) PIN, the Facility Director notified key personnel two hours after the required timeframe.

In addition, according to the OCP, PD, and APD, the youths' legal counsel (i.e., defense attorney, public defender, etc.) should be aware of all critical incidents that impact their clients while the youth is under the care of Probation. However, Probation's current policies do not require them to notify the youths' legal counsel when a critical incident occurs.

Recommendations

Probation Department management:

1. **Ensure Facility Directors (or their designees) at the probation camps and juvenile halls send Preliminary Incident Notifications to their Bureau Chief, Regional Director, and the Bureau Chief's secretary**

within four hours of the incident, and appropriately document the time notification was made.

2. **Revise their policies to require notification of critical incidents to youths' legal counsel.**

Determination

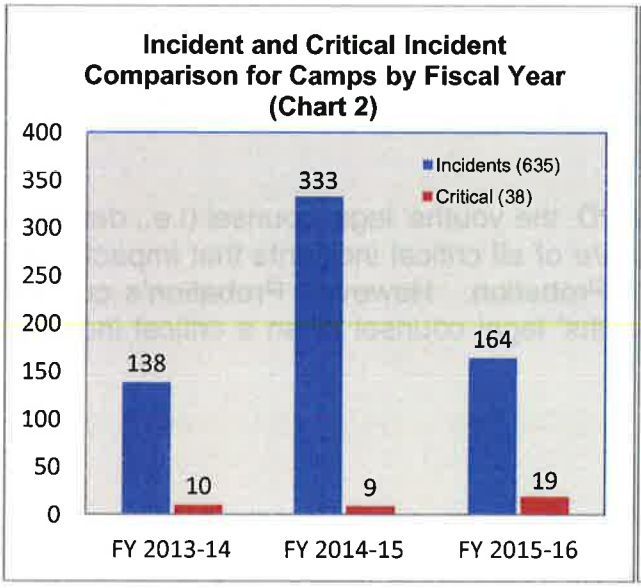
Probation's policies include criteria for critical incidents along with notification requirements, but do not require Probation to document the investigation or justification for concluding if incidents are critical or non-critical. Currently, each camp or hall's Bureau Chief and Bureau Consultant discuss and make a collaborative determination of whether the incident is critical. Without documentation to support their conclusion, Probation cannot ensure all critical incidents are accurately reported.

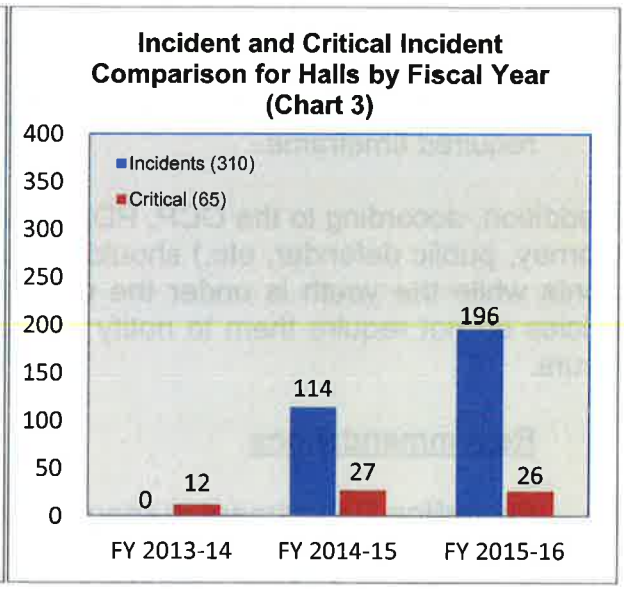
Recommendation

3. **Probation Department management revise their policies to ensure that the justification for determining whether an incident is critical or non-critical is adequately documented.**

Tracking

For the period between July 1, 2013 through June 30, 2016, Probation provided a total of 945 documented incidents on PINs and 103 critical incident memos. Charts 2 and 3 below show a comparison of the total documented incidents versus critical incidents by fiscal year and by facility type.





We reviewed all 945 PINs Probation provided and noted that Probation staff adequately reported critical incidents to the Board when required. However, we noted significant

weaknesses in Probation's tracking of critical incidents. Specifically, Probation does not maintain a centralized tracking system for critical or non-critical incidents. As a result, we could not confirm whether Probation provided us all PINs and critical incident memos. Currently, the Chief Probation Officer's secretary is the custodian of Critical Incident Board memos, with no centralized tracking system or unique tracking identifier assigned to each incident. In addition, Probation management indicated that they could not locate any of the halls' FY 2013-14 PINs, and some of the critical incident records for FYs 2014-15 and 2015-16 were lost or misplaced, due to the transition of various personnel and the deletion of e-mails.

In addition, Probation did not always have a corresponding PIN for each critical incident reported to the Board. Out of the 103 critical incidents during the period, ten related to incident types that may generate media interest or where the Chief Probation Officer may be contacted. As previously indicated, those two incident types do not require a PIN. However, for the remaining 93 critical incidents that required PINs, Probation could not locate 42 (45%).

Probation indicated that their record keeping has improved since FY 2013-14. However, without a centralized tracking system in place to comprehensively track and maintain PINs and critical incidents, Probation cannot guarantee that the information provided is comprehensive or that all critical incidents were appropriately tracked, investigated, and reported to the Board.

Recommendations

Probation Department management:

4. **Develop a comprehensive centralized incident tracking system using unique identifiers for each Preliminary Incident Notification and critical incident.**

5. **Ensure critical incidents are adequately supported with a Preliminary Incident Notification, when applicable.**

Coordination

Several County entities come into contact with youth in the juvenile justice facilities such as DMH, JCHS, LACOE, PD, and APD. Each of these entities has their own definition for critical incidents and their own reporting requirements which are not always consistent with Probation's. For example, the PD defines a critical incident as:

> *"Incidents [that] include but are not limited to physical abuse, verbal abuse, and emotional abuse including threats or intimidation and denial of access to necessary medical and mental health treatment and services."*

However, Probation's definition takes into account the severity of the incident. As a result, a youth can assault a Probation Officer with a weapon and the incident could potentially not be classified as critical depending on the extent of the injury and if staff or youth were admitted to a medical facility. Although this example would meet the criteria of a critical incident using PD's definition, it may not be considered critical using Probation's definition. Without consistent definitions among the various entities, critical incidents may not be consistently reported, and the same types of incidents may be classified differently among the entities.

In addition, DMH, JCHS, LACOE, PD, and APD do not separately track the critical incidents they refer to Probation. Rather, they report the incident based on their own definition to Probation and rely on Probation to track and report the incident. However, as previously mentioned, Probation does not have a centralized tracking system for critical incidents. In addition, Probation's policies do not include procedures for handling incidents that Probation does not classify as critical but the referring entity does. Probation's policies also do not require them to report back to the various entities the disposition of the incident including whether it was investigated or reported to the Board as a critical incident.

To ensure critical incidents are consistently and accurately reported, Probation should work with DMH, JCHS, LACOE, PD, and APD to develop comprehensive critical incident definitions and reporting policies that include procedures for handling incidents that Probation does not consider critical but the referring entity does. In addition, Probation should revise their policies to require that they communicate with the referring entity the disposition of each incident including whether an investigation was performed and any corrective action taken.

Recommendations

Probation Department management:

6. **Work with the Department of Mental Health, Juvenile Court Health Services, Los Angeles County Office of Education, Public Defender, and Alternate Public Defender to develop comprehensive critical incident definitions and reporting policies that include procedures for handling incidents that Probation does not consider critical but the referring entity does.**

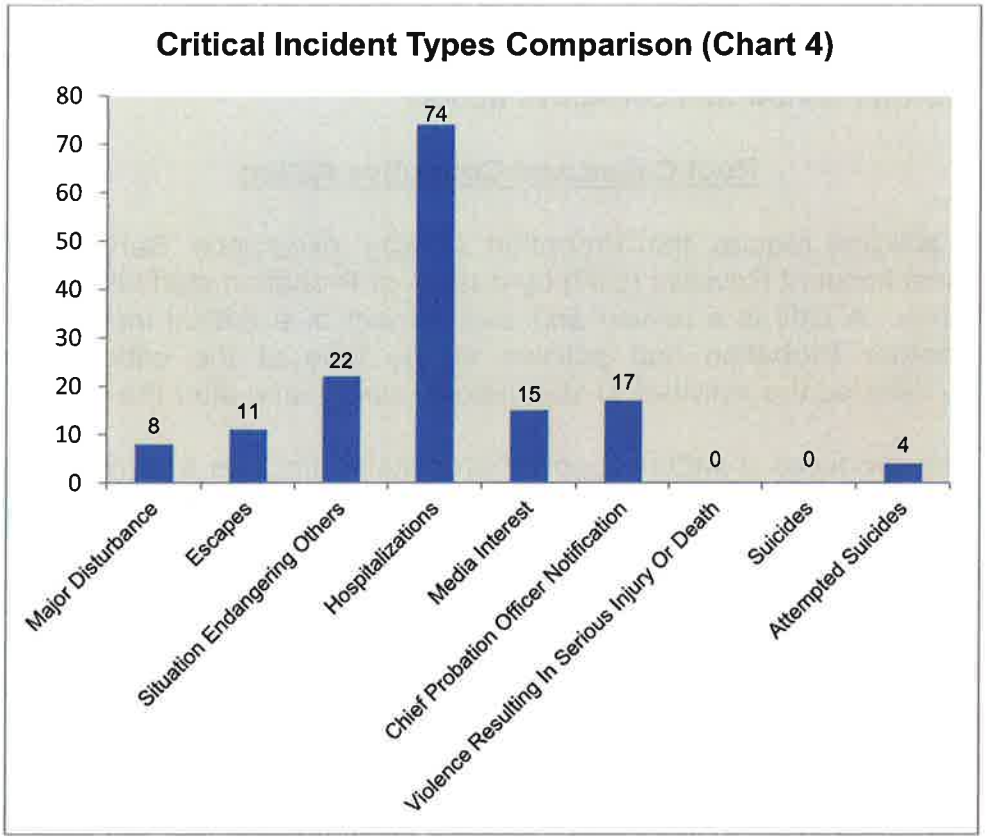
7. **Revise their policies to require Probation to communicate with the referring entity the disposition of each incident including whether an investigation was performed and any corrective action taken.**

Critical Incident Types

As indicated in the Reporting section, Probation reports critical incidents to the Board based on nine critical incident types. However, Probation does not track the critical

incident type being reported. In addition, Probation does not track the results of the information to identify systemic patterns that require further review and corrective action.

We categorized the 103 critical incidents reported by Probation based on Probation's policies. Of the 103 critical incidents, we identified 151 critical incident types. The total number of critical incident types exceeds the total amount of critical incidents reported because some incidents include multiple critical incident types. For example, a minor may have been hospitalized and the incident may generate media interest (see Chart 4 below or Attachment II for additional details broken out by fiscal year).



As illustrated in Chart 4, we noted that 74 (49%) of the 151 critical incident types related to youth hospitalizations with 57 (77%) of the 74 hospitalizations related to a medical condition of the youth, rather than an injury. In addition, reported critical incidents involving only Probation staff were rare, totaling only 10 (7%) of the 151 critical incident types.

As indicated in the Tracking section, Probation does not comprehensively track critical incidents including analyzing and investigating the incidents to identify systemic patterns that require further review and corrective action. As a result, it is difficult to further evaluate whether the high number of hospitalizations or the low number of critical incidents involving only Probation staff are typical; or whether additional training, policies, and oversight may be needed.

In order to promote institutional accountability and ensure critical incidents are adequately evaluated, Probation needs to ensure they document the critical incident type and begin conducting trend analysis to identify systemic patterns that require further review and corrective action.

Recommendations

Probation Department management:

8. **Document the critical incident type(s) reported to the Board of Supervisors.**

9. **Conduct trend analysis to identify systemic patterns that require further review and corrective action.**

Root Cause and Corrective Action

Probation's policies require the Probation Quality Assurance Services Bureau to conduct Critical Incident Reviews (CIR) by a team of Probation staff whenever a critical incident occurs. A CIR is a review and assessment of a critical incident in order to establish whether Probation had policies at the time of the critical incident that appropriately directed the activities of staff before, during, and after the incident.

The CIR team produces a written report that includes findings and recommendations regarding the root cause of the incident, compliance with policy as it relates to the need to create new policy, modification of existing policy, or determining the appropriate training needs which could reduce the likelihood of similar critical incidents from re-occurring.

Probation did not perform CIRs during the three fiscal years we reviewed. Probation indicated that in 2009 due to staffing reassignments and budget restrictions, they discontinued CIRs. Probation indicated they are revising their CIR Policy and plan to resume conducting CIRs within six months. In order to ensure appropriate corrective action is taken to reduce the likelihood of similar incidents from re-occurring, Probation should reinstate the CIRs.

Recommendation

10. **Probation Department management reinstate Critical Incident Reviews to ensure appropriate corrective action is taken to reduce the likelihood of similar incidents from re-occurring.**

CRITICAL INCIDENT TYPES REPORTED BY FISCAL YEAR

	Critical Incident Types		FY 2013-14	FY 2014-15	FY 2015-16	Grand Total
1	Major disturbance (ten or more youth involved)		3	1	4	8
2	Escape other than those from open placements		4	4	3	11
3	Situation endangering probationers, staff, or the facility (1)					
	A	Situation endangering a probationer	-	-	8	8
	B	Situation endangering staff	-	-	7	7
	C	Situation endangering the facility	-	-	7	7
4	Significant medical incident or serious injury requiring admission to an off-site medical facility (1)					
	A	Admission to an off-site medical facility resulting from a physical altercation	1	2	2	5
	B	Admission to an off-site medical facility resulting from a medical condition	9	22	26	57
	C	Admission to an off-site medical facility resulting from a mental condition	-	3	2	5
	D	Admission to an off-site medical facility resulting from an accident	4	2	1	7
5	Incident or situation that may generate media interest, may result in litigation, or is likely to come to the attention of the Board of Supervisors		1	2	12	15
6	Incident or situation in which it is likely that the Chief Probation Officer may be contacted (2)		2	2	13	17
7	Act of violence resulting in serious injury to, or the death of a probationer (1)					
	A	Act of violence resulting in serious injury to a probationer	-	-	-	-
	B	Act of violence resulting in the death of a probationer	-	-	-	-
8	Suicide attempts		-	3	1	4
9	Suicides		-	-	-	-
		Totals (3)	**24**	**41**	**86**	**151**

Footnote:

(1) We separated critical incident type numbers 3, 4, and 7 into subcategories to provide additional details.

(2) We define incidents reported to the Chief Probation Officer as incidents that are detrimental to the Department or may not be captured under the other critical incident categories.

(3) The total amount of critical incident types exceeds the total amount of critical incidents reported because some incidents include multiple critical incident types. For example, a minor may have obtained a serious injury and the same incident may generate media interest.

COUNTY OF LOS ANGELES
PROBATION DEPARTMENT

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CALVIN C. REMINGTON
Interim Chief Probation Officer

November 16, 2016

TO: Supervisor Hilda L. Solis, Chair
Supervisor Mark Ridley-Thomas
Supervisor Sheila Kuehl
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: Calvin C. Remington
Interim Chief Probation Officer

SUBJECT: **RESPONSE TO AUDITOR-CONTROLLERS' RECOMMENDATIONS FOR STRENGTHENING CRITICAL INCIDENT PROTOCOLS TO PROTECT PROBATION YOUTH AND PROMOTE ACCOUNTABILITY**

The Probation Department has reviewed the Auditor-Controller's report and recommendations related to strengthening critical incident protocols to protect probation youth and promote accountability, specifically resulting from a review of the Probation Department's types and prevalence of critical incidents that have occurred over the past three years. The report includes significant issues relating to the reporting, tracking, and maintenance of critical incidents. The Department appreciates the opportunity to respond to the recommendations and is grateful to the Auditor-Controller for their review and professionalism. Attached is the Probation Department's response to the Auditor-Controller's recommendations

The weaknesses identified in the Auditor-Controller's report have been taken in great stride. We are pleased to report that the Department has initiated the implementation of eight of the 10 (80%) recommendations contained in the report. We anticipate implementation of all the recommendations by March 30, 2017, and will provide an update by April 30, 2017. Consequently, we expect that our reporting, documentation, tracking system, and overall critical incident reviews will be more comprehensive as our process is strengthened.

Please contact me if you have any questions or if additional information is needed, or your staff my contact Dave Mitchell, Acting Deputy Chief, Residential Treatment Services, at (562) 940-2508, or Dennis Carroll, Bureau Chief, Detention Services, at (562) 940-2746.

CCR:DM/DC

Attachment

ATTACHMENT

COUNTY OF LOS ANGELES PROBATION DEPARTMENT'S RESPONSE TO THE AUDITOR-CONTROLLER'S RECOMMENDATIONS FOR STRENGTHENING CRITICAL INCIDENT PROTOCOLS TO PROTECT PROBATION YOUTH AND PROMOTE ACCOUNTABILITY

The Probation Department has reviewed the Auditor-Controller's report related to strengthening critical incident protocols to protect probation youth and promote accountability. The Department has initiated the implementation of eight of the 10 (80%) recommendations contained in the report, and anticipates full implementation of all the recommendations by March 30, 2017. The following provides the Auditor-Controller's recommendations, as well as the Probation Department's corresponding response.

Notification

Probation Department management:

1. **Ensure Facility Directors (or their designees) at the probation camps and juvenile halls send Preliminary Incident Notifications (PINs) to their Bureau Chief, Regional Director, and the Bureau Chief's secretary within four hours of the incident, and appropriately document the time notification was made.**

   Response: Agree (underway). When a significant incident occurs to a youth at any camp or hall, Probation staff are required to complete a PIN within four hours of the incident occurring. However, not all critical incidents have a corresponding PIN as one may not be required. For example, in an incident that may generate media interest, Probation sends a memorandum to the Board. Specifically, Facility Directors at the camps and halls (or their designees), are responsible for completing PINs and sending them to key personnel including their Bureau Chief, Senior Director, and Bureau Consultant (Probation Director) within four hours of the incident.

   For the period of July 1, 2013 through June 30, 2016, Probation provided the Auditor-Controller with a total of 945 documented incidents on PINs and 103 critical incident memos sent to the Board of Supervisors. These documents were redacted to protect identifying information related to minors or staff, and were submitted in chronological order, by fiscal year. Of the 945 incidents, 635 (67.2%) were Residential Treatment Services Bureau (RTSB) incidents that occurred in camps, and of those, 38 (5.9 %) required Board notifications. The remaining 310 (32.8%) PINs and 65 Board memos were DSB-related incidents that occurred in juvenile halls.

   The submission of the documentation to the Auditor Controller was a challenge as some of the critical incident records, maintained both electronically and as hard copies, were not easily obtainable. For example, some Fiscal Year (FY) 2013-14 documents were deleted as a result of implementing a two-year e-mail retention policy, and the transition of various personnel during the three years. The current e-mail retention period has been extended to five years. When critical incidents are observed by representatives from the Probation Department or any other Department or agency, they are required to report the incident to Probation management or the appropriate agency. As a result,

a memorandum related to the critical incident is provided to the Board. The Department will continue to enforce this policy, and train management to ensure the policy is adhered to and proper documentation is submitted.

2. **Revise their policies to require notification of critical incidents to youth's legal counsel.**

   Response: Agree (pending). The Department currently has an existing policy which requires that the Court be notified of all incidents leading to the creation of a PIN. The Department believes that it would be appropriate in this circumstance, for the Court or an agent of the Courts to act as the lead agency in notifying the attorney. The Department does not have direct access to the most recent information identifying the youth's currently assigned attorney. The Department will work with the office of the Public Defender, the Alternate Public Defender and the Superior Court to establish a process to notify the youth's legal counsel of critical and non-critical incidents involving their clients.

Determination

3. **Probation Department management revise their policies to ensure that the justification for determining whether an incident is critical or noncritical is adequately documented.**

   Response: Agree (underway). Probation routinely monitors and audits policies and procedures that concern youth and staff safety. The Department is in the process of finalizing policy that requires the justification for determining whether an incident is critical or noncritical to be documented. The tracking system has been developed to memorialize the justification and documentation.

Tracking

Probation Department management:

4. **Develop a comprehensive centralized incident tracking system using unique identifiers for each Preliminary Incident Notification and Critical Incident.**

   Response: Agree (underway). In October 2016, a comprehensive centralized PIN and critical incident tracking system was created. This system identifies each PIN and Critical Incident with a unique identifier and is currently being maintained by the Department's Quality Assurance Services Bureau (QASB).

5. **Ensure Critical Incidents are adequately supported with a PIN, when applicable.**

   Response: Agree (underway). Preliminary Incident Notifications are the foundation for the majority of the resulting Board notifications. As previously stated (Recommendation #1), the submission of documentation to the Auditor-Controller was a challenge as some of the critical incident records, maintained both electronically and as hard copies, were not easily obtainable. All RTSB camp-related documentation, such as PINs and Board memos were provided. However, not all DSB PINs have been provided to the Auditor-Controller, and additional time is required to submit all of DSB's juvenile halls-related documentation. While we believe all critical incidents have been reported to the Board, we request the opportunity to submit the remaining DSB documentation by November 30, 2016, to the Auditor-Controller for consideration. As previously indicated, the Department has extended the email retention period to five years and has implemented a CIR tracking system that is being maintained by QASB which will ensure all critical incidents, when applicable, are supported by a PIN.

Coordination

Probation Department management:

6. **Work with the Department of Mental Health, Juvenile Court Health Services, Los Angeles County Office of Education, Public Defender and Alternate Public Defender to develop comprehensive critical incident definitions and reporting policies that include procedures for handling incidents that Probation does not consider critical but the referring entity does.**

   Response: Agree (pending). The Auditor-Controller indicated that a comparison of Probation's critical incident definition and policies was conducted with the Counties of Kern, Orange, and San Diego, and noted that Probation's definition is consistent with these three County Probation Departments. Although Probation is the lead Department that reports critical incidents to the Board, Probation, DMH, JCHS, LACOE, PD, and APD do not have consistent definitions among the various entities. The concern is that critical incidents may not be consistently reported. Under current policy, all partner agencies that are involved in a critical incident provide information that is included in a memo that is sent to the Board. Such agencies are part of the Board memo distribution list. The Court is notified of all critical and non-critical incidents via a Court report. Probation will work with these partner agencies to more uniformly and consistently identify these critical incidents and share information accordingly. Probation will develop procedures for handling Probation non-critical incidents where referring entities consider them critical. However, based on experience, this occurrence is rare.

7. **Revise their policies to require Probation to communicate the disposition of each incident including whether an investigation was performed and any corrective action taken with the referring entity.**

   Response: Partially Agree (underway). The Department already communicates with the referring entity that an investigation has been initiated. Although non-confidential information may be disclosed, some administrative actions involving sworn Probation staff may be confidential and protected by statute or other privileges, and as such may not be communicated to the referring entity. The Department is prohibited from disclosing any information that will result in conflicts with laws, Peace Officer Bill of Rights, or Memoranda of Understanding. Through the new CIR process, needed corrective action will be implemented and provided to entities as legally permissible.

Critical Incident Types

8. **Document the critical incident type(s) reported to the Board of Supervisors.**

   Response: Agree (underway). The documentation of the critical incident type as reported to the Board has been incorporated in the new comprehensive centralized incident tracking system maintained by QASB.

9. **Conduct trend analysis to identify systematic patterns that require further review and corrective action.**

   Response: Agree (underway). A portion of the critical incident review process is dedicated to identify any systematic or policy failures that resulted in the incident and ensures that Department management will take steps to prevent their reoccurrence. This information will be documented and shared between Bureaus to assist with training and heightened awareness.

Root Cause and Corrective Action

10. **Probation Department management reinstate Critical Incident Reviews to ensure appropriate corrective action is taken to reduce the likelihood of similar incidents from re-occurring.**

    Response: Agree (underway). Although a formal CIR process was in place and was discontinued due to personnel reassignments and a need for a more efficient review process, the Department conducted critical and non-critical incident reviews on an ad-hoc basis. The Department has already reinstated CIRs via a new, formal CIR process where several CIR Committee meetings have already been held. A parallel process remains regarding the referral of suspected policy violations, child abuse allegations, and misconduct to the Department's Internal Affairs and/or other investigative bodies. The Department, in consultation with OIM and County Counsel, is working to finalize a CIR policy with modifications, to implement a more efficient process. QASB is also now responsible for reviewing all PIN-related incidents and identifying non-critical incidents that may need to be reviewed.